

Nebraska Standard Prior Authorization Form For Health Care Services**For Behavioral Providers**

**To file electronically, providers
in Nebraska must register for
access to the online prior
authorization tool:**

To file via facsimile send to:

866.217.6837

To initiate registration, send an email to PMAC@Cigna.com and include the following information:

- **Provider or facility name**
- **Mailing address**
- **Email address**
- **Contact name**
- **Contact telephone number**

Please read all instructions below before completing this form.

Please send this request to the insurance carrier from whom you are seeking authorization. Do not send this form to the Nebraska Department of Insurance, the Nebraska Department of Health and Human Services, or the patient's or subscriber's employer.

On January 1, 2026, all insurers and providers must accept the Nebraska Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

Intended Use: Use this form to request prior authorization for service(s) by an insurance carrier. Some insurance carriers may offer an **online version of this form** on their website or portal, allowing to complete and submit the request electronically.

Submitters should check the insurance carrier's website to understand all data needed, including clinical data, for that insurance carrier. Failure to do so could delay a decision.

By completing and submitting this form, you are attesting that all information is complete and accurate.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; or 6) request a referral to an out of network physician, facility or other health care provider.

Additional Information and Instructions:

Section I - Submission: An insurance carrier may have already entered this information on the copy of this form posted on its website.

Section II - General Information: Urgent reviews: Request an urgent review for a patient if waiting seven days for the authorization could (a) seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or (b) subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Section IV - Provider Information

- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter "Same".
- If the insurance carrier's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same".

Section VI - Clinical Documentation:

- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if required by insurance carrier.

Note: Some insurance carriers may require more information, which must be reflected on their website, in order to process your request. If additional information is required, it will be outlined on their website. Please check their website before submitting your request.

NEBRASKA STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I - SUBMISSION

Insurance Carrier Name:	Phone:	Fax:	Date:
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SECTION II - GENERAL INFORMATION

Review Type: <input type="checkbox"/> Non-Urgent <input type="checkbox"/> Urgent	Clinical Reason for Urgency:		
Request Type: <input type="checkbox"/> Initial Request <input type="checkbox"/> Extension/Renewal/Amendment Previous Auth #:			
<input type="checkbox"/> Continuation of Care	Carrier Name:	Auth #:	
(Please attach approved PA details for Continuation of Care in Section VI)			

SECTION III - PATIENT INFORMATION

Name:	Phone:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Subscriber Name (if different):	Member ID:	Group #:	

SECTION IV - PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider		Service Facility	
Name:		Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:	Phone:	Fax:
TIN #:		TIN #:		TIN #:	
Address (Street): City: _____ State: _____ ZIP: _____		Address (Street): City: _____ State: _____ ZIP: _____		Address (Street): City: _____ State: _____ ZIP: _____	
Requesting Provider/Facility Email Address:					
Primary Care Provider Name: (see instructions)				Phone:	Fax:

SECTION V - SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code (CPT, CDT, HCPCS)	Requested Amount	Start Date	End Date	Diagnosis Description (ICD version)	Code

Inpatient: Yes NoIf Yes: NICU Acute Medical Acute Behavioral Health Post Acute Medical Post Acute Behavioral Health HospiceOutpatient: Yes NoIf Yes: Radiology Medical Behavioral Health HospiceHome Health: Yes No**SECTION VI - CLINICAL DOCUMENTATION (SEE INSTRUCTIONS ON PAGE 1, SECTION VI)**

Contact Name:	Phone:
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